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Sarah Brooks, Chief
California Department of Health Care Services
Medi-Cal Managed Care Division
Program Monitoring & Medical Policy Branch
1501 Capitol Ave., MS 4400
Sacramento, CA 95814

Via Email: Sarah.Brooks@dhcs.ca.gov

Re: Behavioral Health Treatment in Medi-Cal

Dear Ms. Brooks:

The California Association of Health Plans (CAHP) represents 42 public, non-profit, and commercial Knox-Keene licensed health plans across California. We are writing on behalf of our member plans, which include all of the Two-Plan, Geographic Managed Care and County Organized Health System plans serving approximately 7.7 million Medi-Cal beneficiaries in the Medi-Cal Managed Care program. We appreciate the opportunity to provide the Department of Health Care Services (DHCS) with our comments on the draft All Plan Letter (APL) on the Interim Policy for Behavioral Health Treatment (BHT).

CAHP and our member plans support the integration of BHT, including Applied Behavioral Analysis (ABA), into the Medi-Cal benefit package as a means of more effectively serving children with autism spectrum disorder (ASD). These children and their families have long waited for the same level of coverage as in the commercial market. Through our continued partnership and working closely together, we can help to ensure as smooth an implementation as possible.

Overall, CAHP and our member plans appreciate that the APL's efforts to address the concerns we have previously expressed while reiterating the need to work together on the development of rates, the readiness review, and contracting processes. We continue to request the following:

1. Financial risk mitigation in the form of a risk corridor and kick payment for BHT/ABA services;
    a. DHCS should use available commercial plan information on the cost and utilization of BHT/ABA services in order to ensure appropriate funding of the benefit. Use of the rates paid to the Regional Center's vendors will not be sufficient to maintain or increase access to care.

2. DHCS will not take any administrative, regulatory or legal action against MCPs concerning the implementation phase so long as MCPs make best efforts to serve members while developing the appropriate network capacity and similarly ensure that the Department of Managed Health Care (DMHC) will not take any regulatory enforcement actions against MCPs concerning the implementation phase; and

3. Assistance with DMHC during the implementation process as well as ongoing assistance to prevent complaints related to BHT/ABA coverage decisions made in accordance with DHCS's coverage criteria from proceeding to Independent Medical Review (IMR).

Below are our additional comments in regard to the draft APL. Attached is also a redlined version of the draft APL with our suggested edits.

I. Purpose

While the APL provides initial guidance on the administration of the ABA benefit beginning September 15th, in reality, full implementation will take time for both DHCS and the MCPs. The provision of services on September 15th will not reflect the same level of access or timeliness as after MCP networks have been established. The *Purpose* should provide a clear statement regarding roll out of the benefits over time to ensure that beneficiaries and their families clearly understand the progression of implementation.

Moreover, given the intended use of the Medi-Cal Out-of-Pocket Expense Reimbursement (*Conlan*) process outlined later in the APL, it is unclear why the September date is necessary. DHCS could continue to use the Conlan process to pay ABA services claims to allow MCPs additional time to prepare for the benefits. **Consequently, CAHP recommends moving out the managed care effective date beyond September 15th to fall in line with the approval of the State Plan Amendment.**

II. Background

The overall content of the APL only relates to the provision of ABA services; however, the *Background* section lists other modalities used to treat ASD. Although reflective of the CMS Guidance, listing the four categories of service in the APL is not necessary unless the APL addresses these categories. While DHCS has stated intent to provide further guidance on other BHT services, it is not clear that all of the four categories listed are also covered benefits under Medi-Cal; particularly given a lack of evidence based practices in all areas. In order to prevent confusion, the APL *Background* section should be more limited in nature.

III. Interim Policy

A wide array of services are provided to children with ASD, not all of which would necessarily be considered medical in nature. Occupational, speech and physical therapy are common managed care benefits for children with ASD. For MCPs in the commercial market, ABA is also a common treatment

modality. However, the reference within the APL to "other BHT" is vague and could be misconstrued to require MCPs to cover services that should be provided through other venues such as the schools. Additional discussion with the MCPs and appropriate stakeholders is necessary to ensure quality care is provided and reimbursed accordingly for "other BHT" services. In order to allow DHCS to fully vet the scope of these benefits, the draft APL should be limited to ABA.

IV. Continuity of Care

a. General Provisions

Continuity of care is an essential component of integrating ABA services for fragile children with ASD into a managed care environment. Children with ASD are generally adverse to change and can be negatively impacted if a sudden shift in care occurs. As a result, maintaining relationships with pre-existing providers can be essential to maintaining the health of the child. However, quality of care must be upheld to ensure the services provided to children with ASD are beneficial to the child and family. MCPs contract with providers based on their qualifications and ability to effectively treat patients. MCPs should be allowed to continue their contract practices throughout the development of ABA provider networks.

Continuity of care should also mirror to the greatest extent possible the current requirements for Seniors and Persons with Disabilities. Not all providers may wish to continue to treat a child with ASD when the benefit moves to managed care. While MCPs will make best efforts to ensure all appropriate providers are able to continue their relationships with clients, in some cases, that may not be possible if a provider is unwilling to accept the health plans rates, does not meet credentialing requirements, or is of poor quality. The APL should ensure beneficiaries and their families understand the limitations of continuity of care.

b. Regional Centers

CAHP and our member plans appreciate DHCS's willingness to continue service through the Regional Centers (RCs) until a thoughtful and deliberate transition plan for these children can be developed. Many children are being well served by the RC system and will benefit from maintaining existing provider relationships. We look forward to further discussion on the best approach to addressing these children's need.

The guidance is also unclear regarding several RC-related issues including:

- Ensuring continued payment by the RCs, not the MCP, to vendors for services rendered to RC clients until the transition is complete.
- RC's and MCP's responsibility of services and payment of services for children with ASD after September 15, 2014. Scenarios include:
    - A person currently receiving RC services, but not ABA. After 9/15/14, the person becomes eligible for ABA services through the RC.

  - A person who becomes newly eligible for RC services including ABA services after 9/15/14.
  - A person currently receiving ABA services through a RC and the person/ family member believes those services are not sufficient. Can they go to a MCP and request additional hours, etc.?
  - Who will be responsible for ABA services provided to Medi-Cal beneficiaries who are both autistic and mentally retarded? ABA services are an appropriate treatment for both conditions, it is not clear whether the ABA services will be the RC's or the MCP's responsibility.
- What will the impact be on the Early Start Program? Infants and toddlers presenting with suspected developmental delays from birth through three years of age receive early intervention services through this federally sponsored program. Most infants and toddlers with ASD would be eligible for this program through the RCs.
- Timing of this transition period.

We encourage DHCS with the Department of Developmental Services to instruct the RCs regarding maintenance of and payment for ABA services for their current clients during the planning phase in order to protect children already receiving services from loosing coverage.

In addition, when discussing the transition and extending continuity of care, DHCS should be cognizant of the RC current approach to contracting. The RCs do not provide ABA services directly and, in many cases, accept any willing vendor. As a result, not all vendors may be providing the same level of quality care. As the MCPs become responsible for the ABA benefits, ensuring a quality network is a top priority. In order to maintain quality, MCPs must be allowed to contract as they see fit to prevent bad actors from providing ABA services to this fragile population. At no time should MCPs be required to contract with any willing provider.

V. Readiness

CAHP and our member plans appreciate DHCS's continued desire to minimize the administrative impact of implementation on MCPs dually regulated by DHCS and DMHC. Coordination between the two departments on implementation of new BHT/ABA benefits is essential. Streamlining the process through joint requirements, single submissions and agreed upon templates will expedite approval times and prevent unnecessary duplication of effort. It may also be helpful for the two departments to hold joint calls with the MCPs on readiness to ensure consistent messaging and prevent miscommunication.

Given the rolling implementation of the BHT benefits, DHCS and DMHC should both hold MCPs harmless from administrative action or penalty during the startup phase. MCPs making best efforts to serve beneficiaries in accordance with the APL will need the departments' partnership and support to ensure services are provided. Generally programmatic changes occur on a prospective basis and special consideration should be provided to MCPs during this process.

VI. Reimbursement

a. Fee-for-Service Process

CAHP and our member plans appreciated DHCS allowing beneficiaries to submit initial reimbursement claims for ABA services through the Medi-Cal Out-of-Pocket Expense Reimbursement (*Conlan)* process. This approach will help minimize the administrative impact on the MCPs and ensure appropriate reimbursement to families. It is unclear why DHCS has limited the use of this process to such a short period of time as it could be helpful in the roll out of the benefits in managed care. **MCP request that this process be allowed to continue until the approval of the State Plan Amendment by CMS to allow MCPs further time to ensure the appropriate processes are in place to refer individuals to BHT/ABA services**.

The County Organized Health Systems, on behalf of the state, currently perform the out-of-pocket reimbursement process for individuals that are enrolling into the MCPs. This process is time-consuming and administratively complex for the MCPs. For the BHT/ABA benefits, these MCPs would like clarification that DHCS will retain payment responsibility for the BHT/ABA claims and not the MCPs.

MCPs are also seeking further clarification as to how the BHT/ABA benefits will be administered in the Medi-Cal fee-for-service program. Several questions have been raised such as:

- What is the timing of the fee-for-service provider fee schedule?
- Will the fee-for-services treatment authorization request (TAR) process include review and approval of individual treatment plans?
- Will DHCS use the AMA coding structure for the ABA/ BHT benefits?
- Will DHCS establish rates based on service provider type?
- How will the fee-for-service fee schedule impact the managed care rate setting process?

Further information related to the fee-for-service implementation will help plans in the development and establishment of their ABA provider networks.

b. Capitation Payments

CAHP and our member plans continue to advocate in favor of a kick payment methodology BHT/ABA services coupled with a meaningful risk corridor. Overall utilization for these benefits in Medi-Cal is not clear at this time. These services can be extremely costly with estimates upwards of seventy thousand dollars ($70,000) annually per child. Consequently, if the cost and utilization estimates are set incorrectly when rates are developed, MCPs could show large losses in a relatively short period of time. This two pronged approach will also ensure that MCPs are not over or underpaid for the cost of these services.

In order to establish the kick payment, we suggest DHCS work closely with those health plans that have experience providing BHT/ABA benefits in the commercial market. Collection of the cost and

utilization data directly from these health plans will provide DHCS a more accurate picture of the appropriate level of reimbursement to the MCPs. The experience of other states and the Regional Centers is not sufficient as it may not reflect the actual provider costs in California.

In setting the kick payment, DHCS should also include all of the costs associated with BHT/ABA. The evaluation and development of an appropriate treatment plan for children with ASD can be costly as it requires intensive observation and interaction with the child. These costs must be included with the cost of the actual therapy in order for MCPs to appropriately reimburse providers for this time.

VII. Program Description and Purpose

This *Program Description* and sections that follow change the terminology used in reference to ABA services. In the initial sections of the letter, DHCS utilizes the term "ABA services" but then shifts to the use of "ABA-Based Therapy Services". It is unclear why this shift occurs or if it represents different services. DHCS should utilize the same terminology across the APL. We suggested use of "ABA services" as this terminology is more specific and requires that the services actually be applied behavioral analysis as opposed to based on ABA.

CAHP also recommends DHCS more clearly state that, with the exception of continuity of care arrangements, beneficiaries must seek BHT/ABA services through a MCP contracted provider or MCP authorized provider during the implementation phase. There are several references to prescriptions and providers without a clear link to the MCPs' network. To prevent confusion, we have suggested edits through the draft APL.

VIII. Recipient Criteria for ABA-Based Therapy Services

In the recipient criteria, the draft APL states that recipient must be 0 to 21 years of age and have a diagnosis of ASD. This limitation is helpful; however, additional clarify should be added to promote consistency in diagnosing ASD and reduce variation in the clinical evaluation. The APL should include a statement that the diagnostic criteria must be commensurate with the current practice standards such as those described in the Diagnostic and Statistical Manual of Mental Disorders (DSM).

IX. Covered Services and Limitations

As stated in the APL, approval of ABA services is contingent on prior approval by the MCP and the development of an appropriate treatment plan. The development of the ABA treatment plan is limited to only those providers who are appropriately qualified to do so – a qualified autism service provider in accordance with Health and Safety Code Section (c)(1)(C). Although administration of the therapy may occur using a lower level provider, the treatment plan must be develop by the appropriate individual. To provide clarity, we have suggested edits within the text of the draft APL.

MCPs would also request that DHCS provide further clarification regarding the provider participation criteria. Credentialing ABA providers will be problematic as these providers are largely unlicensed and many are not certified. Although use of unlicensed providers for ABA does occur, MCPs have raised concern that, without licensure for the providers rendering ABA services, quality of care will be difficult to ensure. Given the fragile nature of children with ASD, we recommend further discussion on ABA provider participation requirements.

Overall, we appreciate DHCS's thorough approach to describing the treatment plan. In doing so, we also suggest clarifying language to prevent misunderstanding about the nature of a Medi-Cal ABA treatment plan as opposed to an Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP). The IEP and IFSP continue to be important to the long-term progress of children with ASD even with the additional ABA services under Medi-Cal. Often there is a lack of clarity between medically necessary and educationally necessary services. The focus of the services is different and should not be duplicative. To prevent such duplication, the draft should link the treatment plan more specifically to medical goals. The RCs and Local Educational Agencies (LEAs) should be informed of this requirement to avoid a potential debate between the systems.

X. Conclusion

CAHP and our member plans appreciate DHCS continued partnership in the Medi-Cal program and implementation of the new BHT/ABA benefits. The integration of the new BHT/ABA benefits into Medi-Cal is a positive step forward to meet the needs of children with ASD. In order to ensure successful implementation, we are committed to working closely with DHCS in the coming months. We strongly encourage DHCS to develop an appropriate kick payment methodology and risk corridor for BHT/ABA services and work with DMHC to minimize the administrative burden of implementation as we move forward.

Please feel free to contact me if you have any questions regarding our suggested changes to the draft. We look forward to working with you on this issue.

Sincerely,

Abbie A. Totten
Director, State Programs